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STATE HEALTH CARE
LEGISLATION FOR THE
UNINSURED, 1985-87

August 1988

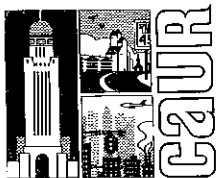


Center for Applied Urban Research
College of Public Affairs and Community Service
University of Nebraska at Omaha



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Executive Summary

The number of persons in Nebraska (about 150,000) and the United States (about 37 million) without health insurance or government health assistance is rising because of the following factors:

- More workers without health insurance benefits
- Less coverage of insured's dependents
- Stricter Medicaid eligibility standards
- Higher insurance costs
- Changes in family composition

Hospitals pay the most for uncompensated care:

- Nebraska's estimated yearly cost for indigent health care is \$9 million
- Shifting costs to all users of hospital services is difficult
- Rising operating costs put pressure on hospital budgets

States are taking responsibility for providing health care to the uninsured in the following ways:

- Creating state funds and programs
- Extending Medicaid eligibility limits
- Contracting with private health providers
- Imposing taxes on health insurance premiums
- Imposing new excise taxes
- Assessing hospitals
- Providing incentives to hospitals for treatment of indigent patients
- Mandating minimum-care standards
- Regulating the transfer of indigent patients
- Extending group health insurance
- Requiring employers to offer health insurance plans
- Providing insurance risk pools for the uninsurable

State Health Care Legislation for the Uninsured 1985-87

Introduction

The percentage of persons in the United States without health insurance that do not qualify for Medicaid or Medicare has been increasing steadily since 1979. Growing numbers of single-parent households, full-time workers becoming part-time, jobs without benefits, and early retirement are a few of the factors contributing to the problem of the medically uninsured.

Dwindling federal support has left the burden of supplying and financing medical care to the states. Delivery of care to those who need it has been hampered by increasing health-care costs and stricter eligibility standards for government-assisted health programs.

As a greater share of the cost shifts to the states, lawmakers are setting new legislative priorities for the medically uninsured. This report focuses on the following types of legislative initiatives:

- Nonrecipients of Medicaid, uninsured (Medically indigent)

This legislation pertains to persons who are ineligible for government programs, such as Medicaid and Medicare (usually because of income), those who are financially unable to meet their medical expenses, and those who are either uninsured or underinsured.

- Medicaid

Changes in laws related to new Medicaid programs or changes in eligibility standards for current programs are discussed. By increasing Medicaid coverage, other health-care programs are less burdened.

- Medically uninsurable (High-risk individuals)

These programs address the needs of persons with pre-existing medical conditions who are uninsurable by private insurers, ineligible for health assistance programs, and unable to pay their health expenses.

- Patient transfers (Dumping)

This discussion focuses on mandatory hospital policies for emergency treatment and transfer of patients, regardless of the patients' ability to pay.

- Medically insured (Special considerations)

This section addresses laws regarding health insurance coverage for persons, spouses, and families in special circumstances, such as job lay-offs, job terminations, employment in small businesses, divorce, and death.

Legislation pertaining to each group is summarized in the tables and explained in the text of the appendix.

Because persons without medical insurance often do not seek routine medical care, because of cost and other barriers, they may first appear at a hospital emergency room. In Nebraska, the poor use hospitals as primary sources of care, especially in urban areas. For example, in Omaha the poor used the following for primary health care: A hospital outpatient center (41.2 percent), a hospital emergency room (12.9 percent), a health clinic (28 percent), and a private doctor (12.2 percent) (Luke, et al., 1985). Because of the overuse of hospitals as primary sources of health care and because hospital costs constitute the highest percentage of total health care costs, this study focuses on laws that effect hospitals and their reimbursement policies, cost-containment, and funding mechanisms. Currently, hospitals are looking for ways to minimize the amount of uncompensated care they provide.

Using the prevailing Medicaid rate, the cost of hospital inpatient services for the medically indigent in Nebraska is estimated to be \$9 million annually. The potential number of medically indigent persons seeking inpatient hospital care is estimated to be 3,600 (Nebraska Hospital Association, 1988). A major issue in today's high-cost medical world is how to continue to provide hospital care for those who cannot pay, while being fair to the poor, the hospital, and society (Myers, 1984).

Many health-related laws are passed each year, but because this study is limited to hospital-related laws, the following are not included: Chiropractry, podiatry, psychiatry, health maintenance organizations, preventive health care, hospice care, and long-term care. Nor does it include lead screening, anti-smoking programs, fraud investigation of Medicaid, pharmaceuticals, developmentally disabled, oral health, dentures, eyeglasses, or hearing aids.

Profile of the Uninsured

From 1980 to 1987, the number of medically uninsured persons in the United States grew by 25 percent to 37 million, while millions of others are underinsured (Gramlich, 1987). This group includes the young and old; employed and unemployed; and the poor, near-poor, and not poor. A national profile of the uninsured was developed based on a National Medical Care Expenditure Survey conducted in 1977 (National Conference of State Legislatures, 1984). The survey indicated that 18.4 million people are always

uninsured, and an additional 16.1 million people are uninsured temporarily. Of the always uninsured:

- Over half were under 25 years of age,
- One-third were children (18 years or younger),
- Almost half had a family income over \$15,000,
- Almost three-fifths were white, and
- Over half were employed all or part of the year.

Despite actions to avoid regional disparities in granting Medicaid benefits, they remain. People living in poverty in the Northeast or the Pacific states are most likely to be covered by Medicaid. The number of Medicaid recipients in Wisconsin, Michigan, Illinois, Indiana, and Ohio grew by 300,000 between 1979 and 1983, and in the Pacific states by about 250,000. In the South, Medicaid coverage declined during this period (Urban Institute, 1987).

In Nebraska, 9.7 percent (155,938) of residents who were 18 years old and older reported themselves to be uninsured in 1986 (Mueller, 1986). This represents a 2.8 percent increase from 1979. These figures likely are underestimates, because only individuals who were 18 years old or older were surveyed. Therefore, it is reasonable to assume that the actual percentage of uninsured persons in the state was closer to the national average of 15 percent in 1986 (Mueller, 1986).

Employers have been the primary providers of health insurance in the United States for many years. In 1987, over 65 percent of nonelderly Americans received health-care coverage directly or indirectly through the workplace (Chollet, 1987). About 95 percent of all private health insurance is purchased through groups, usually at the workplace. Individual policies accounted for only 5 percent of the health insurance market in 1985 (ICF Incorporated, 1987).

Traditionally, the workplace has been linked to health insurance benefits, however, it appears that this relationship is weakening. In 1982-85, the number of workers with health insurance coverage declined by 4.1 percent. Coverage for dependents is also declining. Most uninsured persons are also employed, with three-fourths living in families with consistent employment and over half living in families with year-round, full-time workers (Employee Benefit Research Institute, 1987).

Some reasons for the decline in the number of insured workers are changes in the industrial composition of the economy, movement of jobs from large to small businesses, and changes in family composition.

For example, businesses experiencing the greatest growth have been in areas that do not provide health insurance coverage for employees, such as service and repair businesses. This area, while increasing employment by 61 percent between 1980 and 1985 provided health insurance coverage for only 68

percent of employees. On the other hand, manufacturing, which provides health insurance coverage for about 90 percent of employees, decreased its employment by 4.8 percent (Fraser and Hooper, 1988).

Low income is the characteristic shared most often by the employed uninsured. In Nebraska, the lower the income, the higher the number of workers without health insurance, down to the eligibility range for Medicaid. Of those making \$5,000-\$9,999, 20 percent had no health insurance coverage in 1983 (Luke, et al., 1985). Nationally, 75 percent of 18-64-year-old workers earning \$10,000 per year do not have health insurance (Fraser and Hooper, 1988). However, many persons with higher incomes lack medical insurance too. In 1983, 7.3 percent of Nebraskans earning \$15,000-\$19,999 had no health insurance (Mueller, 1986).

Size of employing firm affects employees health insurance coverage. Smaller firms are less likely to offer health insurance, especially dependent coverage. For example, in 1986, 84 percent of firms with 1-24 employees did not offer group health insurance, compared to only 12 percent of firms with 25-99 employees. In 1984, 48 percent of workers in firms with 1-24 employees were uninsured, while only 15 percent of workers in firms with 25-99 employees were uninsured. However, 26 percent of workers in firms with 500 or more employees were uninsured (Fraser and Hooper, 1988). It is assumed that many of these employees were part-time workers or otherwise were ineligible for group health insurance coverage. While it is too early to determine the extent of these patterns on employer-provided health insurance, it is necessary to monitor this area to determine the potential impact on employees.

Family composition has a clear relationship to insurance status. Nationally, over half of the uninsured (but only one-third of the population) live in families without a spouse. In 1985, 11.9 percent of families with a full-time employee, children, and a spouse present had no health insurance coverage, while the rate was 32.8 percent for families with no spouse present. In addition, many employers no longer offer family coverage (Fraser and Hooper, 1988).

State/Federal Medical Financing (Medicaid)

The Medicaid program is important for three reasons: It is the largest source of financing for medical care for the poor in the United States, its overall costs are affected by the actions of the U.S. Congress and state legislatures, and greater coverage by Medicaid diminishes the pressure on other health-care programs. It should be understood, however, that Medicaid does not cover all medical situations, and usually does not reimburse hospitals fully for their costs.

Medicaid spending by both federal and state governments totaled \$44.8 billion in FY 1984, and increased in FY 1987 to \$49.7 billion (an increase of 10.9 percent). In contrast, during the first year of operation (1966), \$1.5 billion was spent (Lipson, Fisher, and Thomas, 1987).

Since 1976, Medicaid has covered a small and declining percentage of the poor for two major reasons: The number of people living in poverty who are not eligible for Medicaid has increased during the past decade because eligibility standards have not kept pace with inflation. To illustrate, Medicaid covered 65 percent of the poor in 1976, 54 percent of the poor in 1980, 45 percent of the poor in 1982, 38 percent of the poor in 1984 (Fraser, 1987).

Although the noninstitutionalized Medicaid population did not increase during this time, it became poorer and younger (Urban Institute, 1987). There has been an attempt to improve Medicaid's targeting of the proper population, however, there are still many uninsured poor.

Nebraska is not a front-runner in the nation for Medicaid assistance. In 1985, Gormick, using 1980 census information, found that Nebraska ranked 36th nationally and covered 43 percent of the people living in poverty (Gormick, Hadley, and Muller; 1985).

The working poor have faced particular difficulties in maintaining Medicaid eligibility recently because of changes in Aid to Families with Dependent Children (AFDC) eligibility introduced under the Omnibus Budget Reduction Act (OBRA) in 1981. Since 1984, however, eligibility requirements have relaxed somewhat through the Tax Equity and Fiscal Responsibility Act (TEFRA) and the Deficit Reduction Act (DEFRA) of 1984 (Fraser, 1987).

Although Medicaid serves many of the nation's uninsured, many public officials think that the all or nothing approach of Medicaid coverage tends to deter people from making the welfare to work transition. Some states have tried to overcome this problem by allowing coverage to continue for a certain amount of time after recipients become employed or by raising income eligibility limits. Nebraska does not offer such a provision for continuation of Medicaid benefits.

In Nebraska, 59.7 percent of funding is provided by the federal government and 40.3 percent by the state government. Medicaid is the largest provider of health care for the uninsured in Nebraska. State apportionment provides all state funds, because assessments to counties were removed legislatively in 1986. Medicaid payments are made to about 100,000 Nebraskans each year (6.4 percent of the total population) (Nebraska Department of Social Services, 1987).

Medicaid in Nebraska provides medical coverage to families and individuals participating in the following programs: Aid to Dependent Children (ADC), Supplemental Security Income (SSI), or state supplemental programs. Persons whose incomes are sufficient to cover their living expenses, except

medical care, may receive Medicaid coverage if they meet certain eligibility criteria.

The number of persons served and the amount of expenditures are increasing in the state. For example, in FY 1988, Medicaid expenditures totaled about \$230 million, an 11.3 percent increase over FY 1987. Direct payments were made to providers on behalf of an average of 50,103 persons each month, compared to 48,880 persons per month in 1987 (an increase of 2.5 percent).

Inpatient hospital expenditures increased from about \$47.6 million, in 1987 to \$51.9 million in 1988 (a 9-percent increase), and the number of persons served increased from 2,166 to 2,242 (3.5 percent). Hospital inpatient costs represented 22.6 percent of total expenditures.

Outpatient hospital expenditures increased from about \$7 million to \$9.1 million in 1988 (a 29.3-percent increase). The number of outpatients served increased from 6,551 in 1987 to 7,512 in 1988 (an increase of 14.7 percent). Outpatient charges are far less than inpatient billings, representing only 4 percent of total expenditures (Nebraska Department of Social Services, 1987 and 1988).

Clinics served 577 persons in 1988, up from 358 in 1987 (a 61-percent increase). Expenditures went from \$492,141 to \$694,186 (a 41-percent increase). Clinic expenditures represent .3 percent of Medicaid expenditures (Nebraska Department of Social Services, 1987 and 1988).

Although this study does not address long-term health care, it accounts for almost half of Medicaid spending.

Financial Impact of the Medically Uninsured on Hospitals

Hospitals are the largest component of the health-care industry, and provide the most uncompensated care. Uncompensated care is the sum of the cost of providing charity care and the bad debt owed by patients to health-care providers. Charity care is the cost of services provided to patients who are unable to pay. Bad debt refers to the costs owed by patients who can afford to pay for care but for some reason do not.

In the past, most charity care has been provided by public hospitals and financed with state or local government dollars. Fiscal stress has made it difficult for this practice to continue, thereby increasing the burden on private and teaching hospitals. Some states use cost shifting to cover the cost of uncompensated care. Costs are shifted to third-party payers by charging them higher rates for care. Connecticut, Maine, Maryland, Massachusetts, New Jersey, and New York provide for uncompensated care through this rate-setting program. Hospitals add an allowance to each rate to help cover uncompensated care costs.

In states where cost shifting is not allowed, hospitals with even a small amount of uncompensated care (for example, 5 percent of total revenues) may have operating losses because of their limited capacity to shift costs to other payers (National Conference of State Legislatures, 1984). Rate setting is a way to raise revenues and compensate for indigent care and bad debt. Some think that a major disadvantage of this approach is that it usually requires governmental involvement.

Several states assess a fee on hospitals to help pay for indigent care. This program usually operates in combination with other government funding. Assessments are controversial, particularly with health providers who think that such laws place an unfair burden on them.

*Highlights and Trends in Legislative Actions*¹

Many state legislatures addressed the issue of providing health care for the medically indigent in 1985-87. The most important legislative trends included: Creating state programs for indigent care, providing mechanisms for funding indigent care programs, and requiring standards of minimum care. Other significant issues included hiring private contractors to deliver health services, maternal/child health programs, and incentives for hospitals to treat medically needy patients.

Medically Uninsured (Medically indigent). Arkansas, Indiana, Nevada, New Jersey, South Carolina, Washington, and West Virginia established new funds to provide for the care of the medically indigent. The most common sources of funding are property taxes, hospital assessments, and state appropriations. Less popular sources of funding include special excise taxes, Medicare rebates, and sales of hospitals.

Charging hospitals a fee (assessment) to help fund indigent care programs was approved in New Jersey, New York, South Carolina, and West Virginia. By placing a 2-percent tax on all Blue Cross/Blue Shield and other nonprofit plans, Iowa became the first state to impose a surcharge on health insurance premiums for indigent care. Florida and Nevada shifted responsibility for administering programs from states to counties.

Minnesota and Idaho passed laws that changed the legal and operational status of hospitals. Public hospitals were allowed to become public corporations for the delivery of health care to the medically needy. Minnesota exempts these corporations from sales and income taxes. Minnesota, a leader in health-care issues, passed a law requiring child support obligors, if

¹This section is based on the Landes, King, and Polchow publications cited in the references.

enrolled in a group health plan, to provide health and dental insurance for their dependents.

Nevada passed four laws in 1987 for the medically needy, including a requirement that the University of Nevada system continue its program of medical assistance to indigent children.

Utah is an exception in the trend of states becoming more progressive in funding medical care for the indigent. In 1987, Utah repealed its requirement that counties provide medical care to the needy.

Standards of minimum care for hospitals serving the medically needy/uninsured were established recently in Nevada, Texas, and Washington. Nevada also required that all hospitals with over 100 beds provide minimum care to this group.

Medicaid. Legislation to expand Medicaid coverage is one way to address the problem of providing medical care for the poor. Because it provides for most types of care, expanded coverage could help more people meet the eligibility standards for income and category of need.

Eligibility. Sixteen states developed Medicaid standards for children up to age 5 and pregnant women, as permitted in the Sixth Omnibus Budget Reconciliation Act of 1986 (SOBRA). SOBRA allowed states to expand Medicaid coverage to poor children and pregnant women who were living above the AFDC payment levels but below the federal poverty level without extending the AFDC cash assistance. By January 1988, 24 states had implemented this new option. Nebraska, in the 1987-88 legislative session, adopted coverage for pregnant women who live at or below the poverty level (\$7,730 per year for two persons) and for infants up to age 2. The AFDC eligibility standard was 46.1 percent of the poverty level in 1987 (Nebraska Department of Social Services, 1988). Several states extended the income eligibility limit above the poverty level. In many instances, this new program required additional financing or shifting of funds from other sources into the Medicaid budget (Lipson, Fisher, and Thomas, 1987).

Arizona, with its expanding population, passed legislation to toughen the accessibility to health care for nonresidents. In another provision, Arizona provided Medicaid coverage to notch-children, children who are 6-13 years old and live in households with incomes that are above the federal poverty level.

California and Illinois approved medical payments for hospitals that care for AIDS patients. Connecticut and Iowa expanded Medicaid coverage by raising the income limit and expanding coverage to supplemental income recipients. Colorado and Wisconsin started programs for individuals who would have been eligible for assistance under social security had they not exceeded income limits (usually because of new jobs). These innovative programs provided an incentive for people to work without fear of losing

their health care coverage immediately. Participants can retain benefits for up to 9 months after they begin working.

Reimbursement. In the past, hospitals were reimbursed from Medicaid for the actual costs of providing treatment. Now, however, the trend is to base Medicaid reimbursement on diagnostic related groups (DRGs), with the potential of reducing hospital revenues.

In 1987, 14 states had adopted DRGs, including Colorado, Montana, Iowa, South Carolina, Texas, Michigan, Minnesota, New Jersey, Ohio, Oregon, Pennsylvania, South Dakota, Utah, and Washington. States typically adapt the Medicare DRG system to meet their case-mixes and circumstances (Lipson, Fisher, and Thomas, 1987).

Hospitals in North Carolina and South Carolina were affected by recent laws. While North Carolina increased per diem rates to hospitals that serve a disproportionate share of indigent patients, South Carolina imposed cost-containment measures, such as utilization review, preadmission certificates, and mandatory outpatient surgery for indigent patients.

Patient Transfers and Mandatory Emergency Treatment. The increasing problem of indigent patients being refused emergency treatment or being transferred to other hospitals because of the inability to pay prompted several states to take legislative action. Nebraska has no state law requiring mandatory emergency treatment or regulating patient transfers.

California, Florida, Louisiana, Maryland, New York, Pennsylvania, and Tennessee approved legislation that regulates the transfer of patients from one hospital to another because of the inability to pay (dumping).

Nevada's law, passed in 1987, allows hospitals that receive dumped patients to recover payments equal to three times their cost of care from state funds. Louisiana imposes a fine of up to \$5,000 on hospitals that recklessly or intentionally violate the act. It also may suspend medical assistance programs at these hospitals.

Medically Uninsurable. During the past few years, considerable attention has been given to the uninsurable. Usually, these persons have pre-existing conditions which disqualify them for regular group insurance. Most experts think that this group includes about 1 percent of the population. According to Bovbjerg, the number may be increasing for various reasons.

In general, the population is better insured and the number of physicians and other health-care providers has increased. Thus, more people have received medical attention and developed verifiable medical histories. Medical diagnosis may find conditions that prove lasting and expensive to treat. Medical treatment has improved the survival rates of victims of cancer, heart

attack, and other illnesses. This improvement leaves more survivors with adverse medical histories or chronic-care conditions.

Connecticut and Minnesota pioneered the concept of high-risk pools in 1976. As of 1987, 15 states, including Nebraska, have health insurance risk pools for the uninsurable. Iowa, Illinois, and Oregon added such legislation in 1985-87. Policy rationale for this legislation is that people who are willing to pay higher premiums but are unable otherwise to get public or private coverage deserve access to reasonable health insurance.

Pool premiums are guaranteed not to exceed private market premiums by too much because they are capped at a maximum level above prevailing standard premiums. So far, all pools operate with deficits and all provide reasonable coverage to all who are willing to pay.

Nebraska's Comprehensive Health Insurance Pool set its initial rate at 135 percent of standard risk, with a cap of 165 percent. Deductibles range from \$250 to \$1,000, with a lifetime benefit of \$500,000. As of April 1988, there were 754 members, up from 545 in 1987 (Nebraska Department of Insurance, 1988).

Most insurance pools need to be subsidized by the states, either directly or indirectly, because of the higher claims submitted by their members. Nebraska is no exception, and finances its deficits by assessing a fee on health insurers in the state. A tax credit is given to the health insurer for the amount of assessment. In essence, this is a state apportionment.

Given current practices, it seems unlikely that state pools could expand to include a large population without considerably increasing subsidies. Wisconsin passed a law in 1986 to provide premium subsidies to low-income policyholders using the health insurance risk-sharing plan.

Health Insurance (Special Considerations) Another group includes those uninsured because of employment circumstances, including the unemployed, part-time employed, employed in small business, and self-employed. As mentioned earlier, this group is growing. Several states have established programs for individuals who ordinarily cannot participate in group insurance. But, Nebraska has not addressed this issue yet.

Maryland created a group health insurance plan for unemployed individuals and for divorced or widowed spouses not eligible for group insurance. Premiums are paid by the insured. Michigan authorized a plan to provide group insurance to members of an association or group of five or more businesses in the same trade or industry. North Carolina's plan provides insurance to businesses with 25 or fewer employees. Oregon has a similar plan, specifying that employers pay part of employee's premium costs.

Several states passed laws to extend coverage beyond the loss of employment. In several states, spouses and dependents are covered beyond the death or divorce of the group member. Payment of the premium is the

responsibility of the insured or the insured's family. However, group members can obtain rates which they otherwise could not have obtained without extended coverage. Some states allow members to obtain individual coverage when the group coverage expires.

Indiana extends coverage beyond the limiting age for handicapped children if they are primarily dependent on the group member for support. Massachusetts, in 1986, enacted legislation to allow workers to continue group coverage after job termination caused by plant closings. Disabled persons in Missouri can extend their coverage for up to 12 months after the date of disablement. In 1987, New York passed a law that provides premium assistance to laid off workers for up to 5 months.

States are exploring new ways to cope with the medically uninsured, because health-care costs affect everyone. Health-care protection prevents financial catastrophe and encourages people to seek health care before a medical condition becomes acute.

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Appendix

Table 1
State Health Care Legislation for the Medically Indigent, 1985-87*

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Type of care/services
Alaska Chap. 24 1985	Excise tax to fund health programs	Cigarette tax	State	Health- related programs
Arkansas Act 411 1985	Creates indigent health care program	1984 federal Medicaid rebate and state appropriations. Trust fund investment principal and interest.	State	Minimum level
California Chap. 892(AB3216) 1986	Restores funds formerly cut for county medically indigent services programs	State funds	Unknown	Medically indigent services
Connecticut P.A.415(HB5311) 1985	Reimbursement to hospitals	State pays hospitals (not towns) directly for inpatient care. Towns pay 10% of cost for nonresidents, ineligible for general assistance.	State	Inpatient
Connecticut P.A.392(HB5208) 1986	Contract with local health providers	State allocation of funds; 50% must go to community health centers	Department of Health Services	Outpatient maternal/ infant
Connecticut P.A.516(SB936) 1987	Authorizes new rate cap of 175% of average outpatient and emergency fees.	Contingent on federal approval of "disproportionate share exemption" for hospitals serving a large share of patients on public assistance.	Income maintenance officer	Emergency and outpatient

--continued

*All references to legislation in this section are based on information from the following documents:

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Table 1--continued
State Health Care Legislation for the Medically Indigent, 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Type of care/services
Florida Chap. 220(HB1313) 1986	Creates a statewide prenatal program	State funded	Department of Health and Rehabilitative Services	Prenatal, high-risk assessment, education
Florida Chap. 92(HB1384) 1987	Contracts with county hospitals; authorizes demonstration projects for indigent care, links low-income primary services to education of physicians.	Property tax levy for indigent care upon approval of voters; redistributes trust fund surpluses to hospitals providing a substantial amount of indigent care.	State and county	Comprehensive primary care
Georgia p. 827 1985	Requires semi-annual hospital revenue report to obtain certificate of need.	Unknown	State	Report includes: outside funding sources, bad debt, charity care, case information on indigents.
Georgia p. 829 1985	Requires hospitals to provide emergency care to indigent pregnant women in labor; imposes certain obligations on these patients	County reimburses hospitals for care	County	Emergency pregnancy
Georgia p. 744(SBS6) 1986	Requires proceeds (except for those used to pay debt) from hospital sale by a hospital authority or political subdivision be placed in a trust fund. Defines an indigent person as having maximum income of 125% of federal poverty level.	State	Unknown	Indigent care

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Table 1--continued
State Health Care Legislation for the Medically Indigent, 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Type of care/services
Idaho Chap. 240(HB579) 1986	Allows the transfer or lease of county-owned hospital to a nonprofit corporation.	Unknown	County board	Indigent care
Indiana P.L.16(HEA1085) 1986	Shifts responsibilities for indigent care from counties to state; limits hospitals' reimbursement rates for indigent care to 2/3 of claims.	County property tax levy equal to 1984, 85, and 86 average indigent health care payments; state appropriations	State	Hospital and emergency care to prevent death, impairment, or serious dysfunction.
Iowa Chap.239(HF570) 1985	Establishes a tax to expand the medically needy program.	2% premium tax on all Blue Cross/Blue Shield plans and other nonprofit health service corporation plans.	State	Care for the medically needy; limited to certain SSI recipients.
Iowa Chap. 1250 1986	Establishes an indigent obstetrical patient quota at University of Iowa hospitals/clinics; reallocation of state funds to counties.	State funds	Counties	Obstetrical services
Michigan Act 119 1985	Establishes a prenatal care outreach demonstration project	Authorizes additional funds for prenatal program	Department of Public Health	Low-income women and children
Minnesota Chap. 462(HF1875) 1986	Creates a public corporation to govern the St. Paul Ramsey Medical Center for charitable, educational, and scientific purposes. Requires a hospital subsidiary corporation to provide hospital and medical services.	Ramsey County provides funds for care. Corporation is exempt from income and sales taxes.	Corporation	Medical and hospital services to indigent of Ramsey County

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Table 1--continued
State Health Care Legislation for the Medically Indigent, 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Type of care/services
Minnesota Chap. 404(S.F.1721) 1986	Requires child support obligors to name minor child as beneficiary on medical or dental insurance plans.	Unknown	State	Medical
Minnesota Chap. 337(S.F.478) 1987	Establishes demonstration project for low-cost medical insurance to uninsured low-income persons in eight counties.	Unknown	Human Services	Medical
Mississippi Chap. 437(S.B.2116) 1986	Repeals indigent care law and redirects funds to expand Medicaid coverage.	State	Medicaid	Inpatient
New Mexico Chap. 20(HB6) 1986	Provides counties new options for funding indigent hospital care.	Allows counties to impose additional sales tax.	Counties	Inpatient
Nevada Chap. 629 1985	Requires counties to establish fund for medically indigent persons to cover unpaid hospital costs over \$25,000 in counties that have spent 90% of their medically indigent fund.	Counties impose own <i>ad valorem</i> tax of 3 cents for each \$100 of assessed property valuation.	Counties	Inpatient
Nevada Chap. 34 1987	Removes sunset provision that would have eliminated a 3-cent <i>ad valorem</i> county tax.	Unknown	Unknown	Inpatient
Nevada Chap. 377 1987	Requires hospitals with 100 beds or more to provide a minimum amount of indigent care; equal to 0.6% of previous year's net revenue; sets payments at 86% of Medicaid rates.	Unknown	Unknown	Inpatient

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Table 1--continued
State Health Care Legislation for the Medically Indigent, 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Type of care/services
Nevada Chap. 616 1987	Requires Department of Human Resources to expand its Medicaid project to 10,000 participants by 1991.	Unknown	Unknown	Medical and inpatient
Nevada Chap. 646(AB400) 1987	Requires counties to adopt standards for medical and financial assistance to indigent persons; requires counties to pay for emergency care at any facility and other medical services at county-designated facilities.	Unknown	County	Medical inpatient
New Hampshire Chap. 378 1985	Approval for certificate of need contingent on accessibility of new facilities to the medically underserved.	Unknown	Unknown	Medical facilities requiring certificate of need
New Jersey Chap. 204(52024) 1987	Establishes trust fund for state-wide funding of uncompensated hospital care.	Assessment to hospital rate schedule.	Department of Health	Inpatient
New York Chap. 807 1985	Extends a bad debt/charity care pool to December 31, 1987.	Portion of reimbursement rate charged for inpatient services to all payers, except Medicare, distributed to hospitals.	State	Inpatient
New York Chap. 292(S9477) 1986	Creates statewide bad debt/charity pool	Annual assessment of 1.9% on total hospital inpatient revenue.	State	Inpatient
New York Chap. 829(S9310) 1986	Extends date of authorization for issuance of special project hospital bonds.	Unknown	Unknown	Health care for low-income persons

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Table 1--continued
State Health Care Legislation for the Medically Indigent, 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Type of care/services
Ohio Vol. 142(H231) 1987	Specifies computing procedures for counties' share of general assistance; encourages counties to achieve savings.	Unknown	Unknown	Medical
Oklahoma Title S6 1985	Create "Indigent Health Care Revolving Fund"	Income tax check-off placed in revolving fund	State	Medical
Oklahoma SJR12 1987	Constitutional vote to fund city-owned hospitals	Up to 5% mill levy; city property tax	City	Hospitals
Oklahoma Chap. 192 1987	Expands income eligibility guidelines for indigent care; provides for expanded data base.	Unknown	State	Medical
South Carolina Act 201 1985	Creates medically indigent assistance fund to compensate general hospitals for indigent care.	Equal assessments from counties and hospitals. County assessment based on property value, per capita income, net taxable sales, and previous years claims.	State	Hospital services
Texas Chap. 742 1985	Allows contracting for delivery of services to persons ineligible for other publicly funded programs.	State funding on a demonstrated need basis.	Department of Health	Diagnosis and treatment, emergency, preventive medicine
Texas Chap. 1 1985	Requires counties to provide services to persons meeting AFDC requirements but who are categorically ineligible.	State assistance to counties which expend at least 10% of general revenue levy to provide mandatory health care services. \$22 million appropriated in FY-86; \$41 million in FY-87.	County	Hospital, outpatient, family planning, limited

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Table 1--continued
State Health Care Legislation for the Medically Indigent, 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Type of care/services
Texas Chap. 457 1987	Allows county or public hospitals to require other health care providers to seek approval before nonemergency treatment.	Local sales and use taxes; determines a threshold for state assistance based on revenues.	County/state	Nonemergency hospital services
Utah Chap. 181(SB91) 1987	Repeals the requirement that counties provide medical care to indigents.	Repeals the requirement that counties participate financially in the medically indigent program.	Not appli- cable	Not appli- cable
Washington Chap. 5(HB477) 1987	Establishes basic health plan for persons below 200 percent of the federal poverty level.	State funding, nominal copayment by patients.	State	Basic health care
West Virginia Chap. 103 1985	Creates indigent care fund to supplement Medicaid revenues so the state can receive matching federal funds.	State funding; hospital assessment of \$3 million in FY-86.	State	Hospital services
West Virginia Chap. 85(HB2182) 1986	Continues the indigent care fund until June 30, 1987.	State funds; hospital assessment of \$3 million.	State	Hospital services

Table 2
State Health Care Legislation for Medicaid, 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Population Served
Alabama Act 707 (S587)	Creates Alabama Mothers and Babies Indigent Care Trust to expand Medicaid to needy pregnant women, children, and others as necessary.	Omnibus Budget Reconciliation Act of 1986. Federal/state	Medicaid	Pregnant women and children
Arizona Chap. 380(HB2086) 1986	Extends coverage to children under 6 whose household income is above Medicaid eligibility but below federal poverty guidelines; adds children under 18 if they meet AFDC income/resource criteria but not deprivation criteria.	Federal/state	Arizona Health Care Cost Containment System (AHCCCS), Arizona's version of Medicaid.	Children under 18
Arizona Chap. 332(SB1418) 1987	Expands Arizona Health Care Cost Containment System by making it permanent in statute; adding coverage for pregnant women and children up to 2 years with family income below the poverty level and children 6-13 years. Eliminates the hospital rate freeze.	Federal/state	Arizona	Pregnant women and children
California Chap. 1470(AB2594) 1987	Requires consideration of hospital reimbursement for the care of Medi-Cal recipients receiving AIDS treatment; expedites the review of experimental AIDS drugs and their reimbursement.	Federal/state	California Medical Assistance Commission	AIDS patients

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Table 2--continued
State Health Care Legislation for Medicaid, 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Population Served
Colorado Chap. 201(SB139) 1986	Expands eligibility for up to 9 months to persons who would have been eligible for Medicaid but who have accepted jobs (defined as "categorically needy").	Federal Department of Health and Human Services	State Department of Social Services	Eligible
Connecticut P.A. 390(HB7149) 1987	Raises Medicaid eligibility income limit from 120% to 133% of standard of need.	Federal/state	Medicaid	Eligible
Florida Chap. 92(HB1384)	Extends Medicaid eligibility of pregnant women and children up to 100% of the federal poverty line and to elderly and disabled persons up to 90%.	Federal/state	Medicaid	Pregnant women, children, elderly, and disabled.
Illinois P.A. 453(HB295) 1987	Extends Medicaid eligibility for 1 year to children and pregnant women up to 100% of poverty level.	Federal/state	Department of Public Aid	Pregnant women and children
Illinois P.A. 85-929(HB736) 1987	Establishes eligibility for persons with AIDS under existing home and community service waiver.	Unknown	Unknown	Medical care for AIDS patients
Iowa Chap. 239 1985	Extends the medically needy program to Supplemental Security Income related groups.	State general funds	Medicaid	Eligible

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Table 2--continued
State Health Care Legislation for Medicaid, 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Population Served
Louisiana P.A. 760(HB1569) 1987	Raise from 80% to 100% the cost standard to be exceeded for home health care to replace institutional care.	Federal/state	Medicaid	Eligible
Maryland Chap. 286(HB1099) 1987	Extends medicaid eligibility to pregnant women and children under one who fall below the federal poverty level.	Federal/state	Medicaid	Pregnant women and children up to 1 year.
Minnesota Chap. 403(HF243) 1987	Extends Medicaid eligibility level to pregnant women with income up to 133.33% of AFDC income eligibility.	Federal/state	Medicaid	Pregnant women
Mississippi Chap. 513(SB2641) 1987	Extends Medicaid services to all pregnant women with incomes below the poverty level; increases hospital days for children from 15 to 30 years; allows hospitals with disproportionate share of charity work an additional 5% payment.	Federal/state	Medicaid	Pregnant women, children, hospitals
Missouri p. 625 (HB518) 1987	Expands Medicaid to pregnant women who would be eligible for AFDC; pregnant women, infants, and children eligible for SOBRA; expands third-party liability recovery powers.	Federal/state	Medicaid	Pregnant women eligible for AFDC; pregnant women, infants, and children eligible for SOBRA

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Table 2--continued
State Health Care Legislation for Medicaid, 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Population Served
New Jersey Chap. 115(AB2733) 1987	Extends Medicaid eligibility to pregnant women and infants with incomes below the federal poverty level.	Federal/state	Medicaid	Pregnant women, infants
North Carolina Chap. 738(H1514) 1987	Extends Medicaid coverage to pregnant women and children to age five, with income equal to or less than 100% of federal poverty guidelines.	Federal/state	Medicaid	Pregnancy related service
North Carolina Chap. 861(S1018) 1987	Requires the development of a new method to increase per diem rates to hospitals that serve a disproportionate number of indigent patients.	Medicaid Hospital Reimbursement Plan	Division of Medical Assistance	Hospitals
Oklahoma Chap. 179(HB1307) 1987	Expands coverage to pregnant and postpartum women and infants under 1 year with incomes up to 100% of federal poverty level.	Federal/state	Medicaid	Pregnant, postpartum women; infants under 1 year.
Oregon Chap. 872(SB543) 1987	Expands eligibility to pregnant women and children	Federal/state	Medicaid	Pregnant women, children
South Carolina Act 201 1985	Implement cost containment measures.	Unknown	Health and Human Service Finance	Utilization reviews, preadmission certification, mandatory outpatient services, second surgical opinion.

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Table 2--continued
State Health Care Legislation for Medicaid, 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Population Served
Rhode Island Chap. 463(S10) 1987	Expands eligibility to pregnant women and children up to 5 years of age.	Federal/state	Medicaid	Pregnant women, children up to 5 years.
Tennessee Chap. 332(SB867) 1987	Expands Medicaid eligibility	Federal/state	Medicaid	Pregnant women and children
Washington Chap. 335 1985	Extends eligibility standard from 150% to 180% of the state standard of need; change made to comply with federal law.	Federal/state	Medicaid	All eligible
West Virginia Chap. 65(HB2216)	Expands eligibility to indigent pregnant women and children; increases reimbursement rates for prenatal care, delivery, and postpartum care.	Federal/state	Medicaid	Pregnant women, children
Wisconsin Chap. 27(SB100) 1987	Extends Medicaid coverage for up to 12 months following ineligibility for AFDC due to income criteria.	Federal/state	Medicaid	Persons participating in pilot demonstra- tion project.

Table 3
State Health Care Legislation for the Medically Uninsurable (Risk Pools), 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Type of care/services
Florida Chap. 345(SB504) 1987	Extends state high-risk pool beyond October 1, 1987. Offsets insurers' assessments against income or premium tax. Initial premium is 150% of standard risk, with cap at 200%.	Premiums and assessment to insurers	State insurance pool	Insured health service
Illinois P.A. 84-1478 (SB1699) 1986	Establishes state high-risk insurance pool for persons rejected by one insurer; sets premium at 135% of standard risk. Deficits recouped by legislative appropriation.	Premiums, state appropriations	Unknown	Insured health service
Illinois P.A. 85-702(SB630) 1987	Allows state high-risk insurance pool to employ cost containment measures; caps payments to \$500,000 per individual	Premiums, state appropriations	Illinois Comprehensive Health Insurance Plan	Preadmission review, second surgical opinions, HMO coverage, adjustment of premium rate
Iowa Chap. 1156(HF2181) 1986	Creates state high-risk insurance pool as a nonprofit association; sets premium at no more than 150% of average risk premium. Limits out-of-pocket expenses.	Premiums, deficit source unknown	Iowa Comprehensive Health Association	Insured health service
Kansas Chap. 178(SB121) 1986	Creates a joint underwriting plan for medically uninsurable; implemented by future legislative action	Unknown	Unknown	Insured health service

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Table 3--continued
State Health Care Legislation for the Medically Uninsurable (Risk Pool), 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Type of care/services
Maine Chap. 347(LD1770) 1987	Establishes state high-risk insurance pool; deficits funded by annual hospital assessments; enrollment limit 300 persons.	Premiums, hospital assessments not to exceed .0015% of hospital revenues.	Maine High-Risk Insurance Organization	Insured health service
Montana Chap. 595 1985	Establishes state high-risk insurance pool.	Unknown	Unknown	Insured health service
Nebraska LB 391 1985	Establishes state high-risk insurance pool. Sets initial premium at 135% of standard risk; subsequent premiums at 165%. Lifetime cap per person is \$500,000.	Premiums, reduction in insurers' tax credit	Unknown	Insured health service
New Mexico Chap. 154(SB294)	Establishes state high-risk insurance pool	Premiums, insurer assessments	New Mexico Comprehensive Health Insurance Pool	Insured health service
North Dakota Chap. 322 1985	Reduce number of rejections from insurers for eligibility; sets residency at 6 months, provides coverage in the first 6 months, if extra premium is paid.	Premiums, deficit source unknown	Comprehensive Health Association	Insured medical service
Oregon Chap. 838(SB583) 1987	Creates state high-risk insurance pool; sets premiums to 150% of standard risk.	Premiums, deficit source unknown	Oregon Medical Insurance Pool	Insured medical service

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Table 3--continued
State Health Care Legislation for the Medically Uninsurable (Risk Pool), 1985-87--continued

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Type of care/services
Tennessee Chap. 870(HB1778) 1986	Establishes state high-risk insurance pool; sets premiums at 150% of standard risk. Employer cost containment.	Premiums, assess- ments on insurers not to exceed \$2 million per year.	Tennessee Comprehensive Health Insurance	Insured medical service
Washington Chap. 431(HB99) 1987	Creates nonprofit comprehensive high-risk health insurance pool.	Premiums, assess- ments on health insurers, health care service contractors, and HMOs.	Unknown	Insured health service
Wisconsin Acts 29 and 120 1986	Creates high-risk insurance pool.	Premiums; deficit source unknown	Unknown	Insured health service

Table 4
State Health Care Legislation
Mandatory Emergency Care Patient Transfers (Dumping), 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Type of care
California Chap. 1240(SB12) 1987	Regulates emergency treatment of patients and their transfer to other medical facilities; prohibits basing emergency treatment on patients characteristics; makes hospital compliance a condition of licensure.	Unknown	State	Emergency and hospital transfer
Florida Chap. 125(SB1036) 1986	Requires hospitals with full-time emergency rooms to treat patients for emergencies, regardless of ability to pay. Sets guidelines for transferring patients.	Unknown	State	Emergency, inpatient transfer
Louisiana P.A. 998(HB1058) 1986	Requires hospitals to provide emergency services and physicians to provide diagnostic services to patients regardless of the economic status or other characteristics.	Unknown Violations invoke a hospital fine of not more than \$5,000 and possible suspension from the medical assistance program.	State	Emergency, diagnostic services
Maryland Chap. 849(SB711) 1986	Adopts regulations governing transfer of patients between hospitals.	Unknown	Department of Health and Hygiene	Inpatient transfer
Massachusetts Chap. 107(S465) 1986	Requires hospitals that refuse to treat patients due to lack of source of payment to find a facility to adequately treat patients.	Unknown	State	Inpatient transfer

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Table 4--continued
State Health Care Legislation
Mandatory Emergency Care Patient Transfers (Dumping), 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Type of care
Nevada Chap. 377(AB289) 1987	Requires hospitals to provide emergency medical care to all patients, regardless of financial status.	Hospitals that receive "dumped" patients can recover treble costs.	State	Emergency
New York Chap. 121(A3183) 1987	Prohibits general hospitals to transfer cases to other hospitals because of inability to pay.	Unknown	State	Inpatient transfer
Oregon Chap. 386(HB2354) 1987	Prohibits hospitals from denying emergency care to patients because of inability to pay.	Unknown	State	Emergency
Pennsylvania Act 89(SB293) 1986	Requires health care providers to provide emergency care to persons regardless of ability to pay; transfers are limited to facilities that cannot provide "proper" treatment; compliance is a condition of licensure.	Unknown	State	Emergency, inpatient transfers
Tennessee Chap. 711(SB1410) 1986	Requires regulation of involuntary transfers of inpatients for purely economic reasons.	Unknown	Department of Health and Environment	Inpatient transfers

Table 5
State Health Care Legislation For Medical Insurance
Under Special Circumstances, 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Type of care
Connecticut P.A. 274(HB5047) 1987	Increases extension period for group health policies from 39 to 78 weeks for members losing jobs; from 39 to 156 weeks for spouse and children in divorce or death of member.	100 to 102% of current premium, paid by family or member	Insurance company	Insured health service
Colorado Chap. 84(SB51) 1986	Requires extension option of 90 days after termination of employment or reemployment for member and dependents. Requires option for individual coverage after group coverage expiration.	Member paid premium	Nonprofit hospital, medical-surgical, health service corporations	Insured health service
Delaware Chap. 461(SB578) 1986	Permits self-employed persons to deduct half the amount of health insurance costs for themselves and family, above the federal government deductible for medical expenses.	Tax deductions	State	Health insurance costs
Georgia p. 688 (HB212) 1986	Requires group health insurance plan and other medical benefit plans to have a continuation option for three months for group members whose coverage has been terminated.	Premiums paid by group member	State	Insured health service

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Table 5--continued
State Health Care Legislation For Medical Insurance
Under Special Circumstances, 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Type of care
Illinois P.A. 84-556 1985	Requires group health and accident policies to contain a provision for continuation for coverage for spouse and children after employee's divorce or death. After 2 years, person may convert to individual coverage.	Premium paid by spouse/dependents	Insurance group	Insured health service
Indiana P.L. 165(HBA1432) 1986	Requires health coverage for dependent child of group policy continue past the limiting age if child is handicapped and dependent on parent for support.	Unknown whether employee pays higher premium	Insurance group	Insured health service
Iowa Chap. 1124(HF2465) 1986	Requires group members whose employment is terminated to receive coverage for 9 months.	Employee-paid premiums	Insurance group	Insured health service
Kentucky Chap. 163(SB274) 1986	Allows continuation of group policies upon termination of group membership under special circumstances.	Unknown	Insurance group	Insured health services
Maine Chap. 684(LD2273) 1986	Requires group coverage to continue for 6 months to 1 year or convert to individual policies for employees laid off or terminated for work-related injury or occupational disease.	Employee-paid premium, guaranteed to not be more than group rate in effect	Insurance group	Insured health services

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Table 5--continued
State Health Care Legislation For Medical Insurance
Under Special Circumstances, 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Type of care
Maryland Chap. 681 (SB632/HB922) 1986	Provides a continuation for up to 18 months to spouse/dependents upon death of group member.	Spouse-paid premium at group rate	Insurance group	Insured health services
Maryland Chap. 747(HB840) 1986	Creates Maryland Group Health Insurance Plan, provides for group health insurance for unemployed persons and divorced or widowed spouses ineligible for group insurance.	Unknown	Insurance Commissioner	Insured health services
Massachusetts Chap. 579 (SB1978) 1986	Requires insurers to continue coverage to employees terminated by plant closing or partial closing for 90 days or until they are eligible for other insurance.	Unknown	Insurance group	Insured health services
Michigan Act 121(HB5018) 1986	Establishes the Multiple Employer Welfare Arrangement (MEWA) for health benefits to employees. Employers must be members of an association of five or more businesses in same trade or industry.	Premiums, MEWA assessment for security fund	State	Insured health services
Minnesota Chap. 337(SF478) 1987	Requires insurers to continue coverage for terminated or laid-off employees for up to 18 months; provides for individual coverage.	Unknown	Insurance group	Insured health services

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Table 5--continued
State Health Care Legislation For Medical Insurance
Under Special Circumstances, 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Type of care
Missouri Revised Stat. 376.421-376.442 1985	Requires insurers to continue coverage for up to 9 months following termination of employment. Extends major medical coverage to totally disabled for 12 months after disablement date.	Unknown	Insurance group	Insured health services
Nevada Chap. 805(SB155) 1987	Requires employers with fewer than 20 employees to offer continuation after termination; makes option available to spouse/dependents upon death of employee.	Employee/survivor-paid premium	Insurance group	Insured health services
New Hampshire Chap. 163(H155) 1986	Continues health and accident insurance for divorced and separated spouses until remarriage, and provides for conversion after remarriage.	Spouse-paid premium	Insurance group	Insured health services
New York Chap. 210(S7) 1987	Ends 6-month continuation coverage for employees and covered dependents under COBRA.	Unknown	Unknown	Insured health services
New York Chap. 539(A6880) 1987	Establishes a 5-month health insurance benefit for laid-off workers.	Workers to receive assistance to help pay premiums	State	Insured health services
North Carolina Chap. 765(S759) 1987	Provide health insurance program for businesses with 25 or fewer employees.	Unknown	North Carolina Health Insurance	Insured health services

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Table 5--continued
State Health Care Legislation For Medical Insurance
Under Special Circumstances, 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Type of care
Oklahoma Title 36 1985	Allows maternity coverage to be continued after termination of employment.	Unknown	Unknown	Maternity benefits
Oklahoma Chap. 150(SB545) 1986	Allows disabled employees or survivors to continue health and dental insurance if they are in the State Employees Disability Program.	Employee/survivors-paid premium	State Employees Disability Program	Insured health and dental benefits
Oregon Chap. 591(HB2594) 1987	Offers health insurance to employers with less than 25 employees. Part I covers acute and recovery expenses; Part II covers enhanced coverage and family coverage.	Employer/employee-paid premiums. Employer receives tax credits for contributions.	Insurance Pool Governing Board	Acute Care (Part I) and Enhanced Care (Part II)
Tennessee Chap. 716(SB1507) 1986	Provides coverage of divorced or surviving spouses up to 15 months. Extends pregnancy coverage until at least 6 months after pregnancy ends.	Spouse-paid premiums	Insurance companies	Insured health services/ maternity benefits
Washington Chap. 223(HB1630) 1986	Requires insurers to continue unqualified coverage of a spouse and dependents in divorce or death of insured member. Prohibits termination due to change in physical or mental health without certain conditions.	Unknown	Insurance companies	Insured health benefits

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Table 5--continued
State Health Care Legislation For Medical Insurance
Under Special Circumstances, 1985-87

State, law number, year passed	Description/ purpose of law	Financial mechanism	Administrative mechanism	Type of care
Wisconsin Act 311(AV12) 1986	Requires parents to accept liabilities for minor child's health expenses including child-birth unless they exceed 5% of parents' federal adjusted gross income. Requires insurance companies to provide coverage for children of the child until the child is 18 years old.	Parents' insurance premiums	Insurance companies	Grandchild's health care expenses

Laws passed in 1985-87

Medically Indigent

ALASKA, 1985, Chap. 24. Increases the state cigarette excise tax with the legislature's intent that the additional tax proceeds be used principally to fund health-related programs.

ARKANSAS, 1985, Act 411. Creates the Arkansas Indigent Health Care Program which will be funded by a 1984 federal Medicaid rebate and state appropriations for medically indigent programs. Funds are deposited in the Health Care Investment Trust Fund. Principal and interest payments resulting from investments may be transferred to the Indigent Health Care Fund. Hospitals must provide a minimum level of care to be reimbursed.

CALIFORNIA, 1986, Chap. 892. Restores \$25 million of the \$50 million cut by the governor from the budget in June for county medically indigent programs.

CONNECTICUT, 1985, P.A. 415 (HB 5311). Requires the state to pay hospitals directly for inpatient care of people eligible for general assistance instead of reimbursing towns for this payment, and requires towns to pay 10 percent of the cost of inpatient care for nonresident general assistance eligibles and people in workfare programs.

CONNECTICUT, 1986, P.A. 392 (HB 5208). Requires the Department of Health Services to contract annually with local health providers for outpatient services for needy women and infants. The department must allocate at least 50 percent of any funds appropriated for such contracts to community health centers in specified cities. Half of the allocation for these centers must be for needy infants and pregnant women; the remaining half is for health services for other medically indigent persons.

CONNECTICUT, 1987, P.A. 516 (SB 936). Authorizes the Income Maintenance Commissioner to increase the rate cap up to 175 percent for outpatient clinic and emergency room visits at hospitals receiving state funds of the average fee for outpatient visits at qualifying hospitals. The commissioner must receive federal approval for a "disproportionate share exemption" which is granted to hospitals serving an unusually large number of patients who receive public assistance. Authorizes the commissioner to make grants-in-aid to the same hospitals.

FLORIDA, 1986, Chap. 220 (HB 1313). Requires the Department of Health and Rehabilitative Services to provide a statewide prenatal care program for low-income pregnant women, including early, regular prenatal care; an assessment of high-risk conditions; and education. The department is to establish by rule the eligibility criteria for prenatal care for indigent pregnant women when state funds are used for prenatal care.

FLORIDA, 1987, Chap. 92 (HB 1384). Expands existing state-funded primary care programs to additional counties by allowing the state to contract with counties to provide comprehensive primary care services through county public health units or county-owned and operated hospitals. Allows counties to establish special districts overseen and administered by county-appointed health care boards to help fund indigent health care services. Allows districts to levy property taxes for indigent care subject to a vote of the electorate. Redistributes the Public Medical Assistance Trust Fund surpluses to hospitals providing a substantial amount of indigent care through a formula designed to target major Medicaid and charity care providers. Establishes the Florida Small Business Health Access Corporation Act, and requires the corporation to organize employers of 24 or fewer full-time employees and facilitate the provision of group health insurance to such employers and employees, and their dependents. Provides that the corporation shall operate initially in Hillsborough County and a multicounty rural site (to be designated by the corporation). Directs the Department of Health and Rehabilitative Services to plan and establish medically indigent demonstration projects and to evaluate the impact of each on improving access to services by persons who are medically underserved. Directs the department to contract to assist in funding one rural and one urban demonstration primary health training project that allows medical students, interns, and residents to provide primary care services to low-income persons.

GEORGIA, 1985, P. 827. Requires every hospital in the state to submit a semiannual report to the Health Planning Agency summarizing gross revenues, including sources of outside funding, bad debts, charity care, and case information about indigent care. A certificate of need will not be granted to any hospital that has not submitted a report.

GEORGIA, 1985, P. 829. Amends the law requiring hospitals to provide emergency services to indigent pregnant women in labor and requiring counties to reimburse hospitals for that care. Provides eligibility standards and imposes certain obligations upon women receiving the emergency services.

GEORGIA, 1986, P. 744 (SB 56). Provides that upon the sale of a hospital by a hospital authority or political subdivision, all proceeds of the sale, other

than proceeds used to retire indebtedness of the hospital, must be placed in a trust fund to be used for the sole purpose of providing indigent health care. Defines an indigent person as having a maximum income of 125 percent of the federal poverty level.

IDAHO, 1986, Chap. 240 (HB 579). Allows the transfer or lease of a county-owned hospital by the Board of County Commissioners to a nonprofit corporation, limits terms of the lease to 99 years, and requires the nonprofit corporation to provide care for indigent patients.

INDIANA, 1986, P.L. 16 (HEA 1085). Requires the state to pay for hospital care for the indigent (HCI) beginning January 1, 1987. Establishes a state fund that is funded by a property tax levy in each county equal to the county's average 1984, 1985, and 1986 HCI obligations that were actually paid. Requires the state Welfare Department to establish income-eligibility guidelines for HCI recipients.

IOWA, 1985, Chap. 239 (HF 570). Assesses a 2-percent premium tax on all Blue Cross/Blue Shield plans and other nonprofit health service corporation plans. Expands the medically needy program. Eligibility is limited to certain recipients of Supplemental Security Income.

IOWA, 1986, Chap. 1250. Establishes an indigent patient obstetrical quota for the University of Iowa Hospitals and Clinics, and reallocates \$1.1 million of the state appropriation to counties for delivery of obstetrical services to eligible persons.

MICHIGAN, 1985, Act 119. Appropriates funds to the Department of Public Health for a prenatal care outreach demonstration program. Authorizes additional funds for a prenatal care outreach program designed to reach low-income women and children in need of health care and support services if the department finds previous appropriations inadequate.

MINNESOTA, 1986, Chap. 462 (HF 1875). Creates a public corporation and directs it to create a subsidiary corporation to govern the St. Paul Ramsey Medical Center for health care delivery, research, and education. Prohibits the corporation from using any part of its assets or income for purposes that are not exclusively charitable, educational, or scientific. Exempts the corporation from income and sales taxes, requires the hospital subsidiary corporation to provide hospital and medical services to the indigent of Ramsey County, and allows Ramsey County to provide funds for that care to a provider selected by the county, with or without public bid.

MINNESOTA, 1986, Chap. 404 (SF 1721). Requires child support obligors to name the minor child as beneficiary on any health or dental insurance plans available to the obligor through a group, employer, or union, unless group dependent health insurance coverage is available at a more reasonable cost.

MINNESOTA, 1987, Chap. 337 (SF 478). Requires the Commissioner of Human Services to establish a demonstration project to provide low-cost medical insurance to uninsured, low-income persons in eight counties. The purpose of the demonstration project is to determine the feasibility of a statewide program of medical insurance for uninsured, low-income persons.

MISSISSIPPI, 1986, Chap. 437 (SB 2116). Repeals the state indigent care law. The intention is for the funds currently going for indigent care to be used to augment the Medicaid program, expanding eligibility from above 16 percent of federal poverty level to 50 percent.

NEW MEXICO, 1986, Chap. 20 (HB 6). Provides counties new options for funding indigent hospital care. Allows counties to impose an additional 2/8 percent gross receipts tax (sales tax) (referred to as second and third 1/8 percent increments) beyond the current limit of 1/8 percent. Class A counties must use all revenue raised from the second and third increments to fund indigent hospital care (a minimum of \$1 million for each additional increment must go to fund indigent care). Other counties must use all revenue raised from the second increment and half of the revenue raised from any third increment to fund indigent care. Counties having a third increment may allow future referendums to determine if the third increment should be continued.

NEVADA, 1985, Chap. 629. Requires counties to establish a fund for medical assistance to indigent people, with the county financing the fund through an *ad valorem* tax of three cents on each \$100 of assessed property valuation. Three-tenths of one cent of the *ad valorem* tax shall be deposited in a statewide fund. This fund, without additional refinancing by the state, shall cover unpaid hospital costs over \$25,000 in counties that have spent 90 percent of their medically indigent fund.

NEVADA, 1987, Chap. 34 (SB 17). Removes the "sunset" provision that would have eliminated a 3-cent *ad valorem* county tax that was instituted in 1985 for the medical support of indigents.

NEVADA, 1987, Chap. 377. Requires hospitals with 100 beds or more to provide a minimum amount of indigent care, equal to 0.6 percent of the previous year's net revenue, and sets payments for indigent care at 86 percent of Medicaid rates.

NEVADA, 1987, Chap. 616 (SB 27). Requires the Department of Human Resources to expand its joint capitated Medicaid project with the School of Medicine of the University of Nevada to 10,000 participants by July 1, 1991. Requires the University of Nevada system to continue its program of medical assistance to indigent children.

NEVADA, 1987, Chap. 646 (AB 400). Requires counties to adopt standards for medical and financial assistance to indigent persons, establishes a minimum eligibility standard for medical assistance, and requires counties to pay for emergency medical care at any facility and for all other medically necessary care at medical facilities designated by the county.

NEW HAMPSHIRE, 1985, Chap. 378. Adds as a certificate of need approval the degree to which the proposed expansion or new institutional health services will be accessible to persons who traditionally are medically underserved.

NEW JERSEY, 1987, Chap. 204. Establishes the New Jersey Uncompensated Care Trust Fund to provide a statewide mechanism for the funding and payment of uncompensated care in general acute care hospitals. Provides for a uniform statewide uncompensated care add-on to be applied to each hospital's schedule of rates, as determined by the Department of Health. Requires hospitals that collect more than they require to cover their uncompensated care costs to pay the net difference into the fund, and requires hospitals that collect less than they require to cover their uncompensated care costs to receive additional revenues from the trust fund. Requires the Hospital Rate Setting Commission to approve a hospital's "reasonable" uncompensated care costs and enables the commission to require a hospital to submit a cost-reduction plan, if the hospital provides inefficient or inappropriate uncompensated care. Provides that the commission may prospectively reduce a hospital's uncompensated care payments for failure to submit the plan.

NEW YORK, 1985, Chap. 807. Extends a bad debt and charity care pool from January 1, 1986 to December 31, 1987. The pool is funded by a portion of the rate of reimbursement charged for hospital inpatient services to all payers, excluding Medicare. Major public hospitals will receive distributions based on their share of statewide reimbursable costs, excluding Medicare costs. All other hospitals will receive distributions proportionately based on need.

NEW YORK, 1986, Chap. 292 (S 9477). Revises the method for financing hospital bad debt and charity care for the period July 1, 1986 to December 31,

1987, through the creation of a statewide pool funded by an annual assessment of 1.9 percent on total hospital inpatient revenue. This assessment replaces the previous assessment on hospital Medicare revenue used to finance statewide bad debt/charity care. No hospital's contributions to the statewide pool are to increase, and each hospital is to receive approximately the same amount in distributions from the pool.

NEW YORK, 1986, Chap. 829 (S 9310). Extends to March 31, 1987, authorization for the issuance of special hospital project bonds on behalf of certain secured hospital borrowers to assist in providing adequate health care to low-income persons.

OHIO, 1987, Vol. 142 (H. 231). Specifies procedures for computing counties' shares of General Assistance Medical Assistance costs and includes an incentive plan to encourage counties to achieve savings in General Assistance Medical Assistance.

OKLAHOMA, 1985, Title 56. Provides for an income tax check-off to provide funding for indigent health care. The monies received from the program shall be deposited in the Indigent Health Care Revolving Fund to be used to implement the provisions of the Oklahoma Indigent Health Care Act.

OKLAHOMA, 1987, SJR 12. Calls for a vote of the people on a constitutional question allowing a maximum five-mill levy against property valuation in Oklahoma cities to operate and maintain city-owned hospitals, subject to approval of city voters.

OKLAHOMA, 1987, Chap. 192. Expands income eligibility guidelines for the Oklahoma Indigent Health Care Program and provides that eligibility will be determined by the standard of need, instead of assistance payment levels. Provides for development of an expanded data base on the extent of medical indigence in the state, and creates a 15-member Council on Health Care Delivery to determine the problems associated with health care access in Oklahoma, and to review possible solutions.

SOUTH CAROLINA, 1985, Act 201. Creates the South Carolina Medically Indigent Assistance Fund financed by equal contributions from county and general hospital assessments. Funds will be used solely to compensate general hospitals for providing medical care to the medically indigent. County contributions will be assessed by a formula based on property value, per capita income, net taxable sales, and consideration of previous year's claims. Contributions to counties from the fund must be credited against the county assessment.

TEXAS, 1985, Chap. 742. Creates a primary health care services program allowing the Department of Health to contract with existing providers or directly deliver services to individuals not eligible for other publicly funded programs. Priorities specified in the act include diagnosis and treatment, emergency services, family planning, preventive health, health education, and diagnostic services. Fees may be charged for services rendered.

TEXAS, 1985, Chap. 1. The Indigent Health Care and Treatment Act requires counties to provide the following health care services to persons who meet the basic income and resource requirements for Aid for Families with Dependent Children but who are categorically ineligible: Hospital services, rural health clinic services, lab and x-ray services, family planning, physician services, and limited-skill nursing facility services. Counties may require eligible persons to see only specified providers and pre-authorize any service for non-emergency care. Counties are not liable for services to a person who resides within an area served by a public hospital or hospital district that has a legal obligation to deliver care to the medically indigent. Public hospitals and hospital districts are subject to similar indigent care rules. State assistance is available to counties that expend at least 10 percent of their general revenue levy to provide mandatory health care services. The state will pay 80 percent of actual payments after the 10 percent expenditure level has been reached. The act also creates an Indigent Health Care Assistance Fund to pay the state portion of indigent care costs and to pay for other indigent care programs, for example, social security program for children and prenatal services for low-income individuals. A total of \$22 million was appropriated from the fund in FY-86, and \$41 million in FY-87.

TEXAS, 1987, Chap. 457. Allows county or public hospitals responsible for indigents within their jurisdictions to require other health care providers to seek advance approval from the county or public hospital before offering non-emergency indigent services. Authorizes the commitment of local sales and use taxes to indigent health care purposes, but simultaneously counts resultant tax revenue with property tax revenue in determining the threshold at which state assistance for indigent health care commences.

UTAH, 1987, Chap. 181 (SB 91). Repeals the requirement that counties provide medical care to indigents and participate financially in the medically indigent program.

WASHINGTON, 1987, Chap. 5. Establishes the Washington Basic Health Plan, governed by an administrator who is appointed by the governor and responsible for designing a schedule of basic health care benefits. Subsidizes premiums,

based on gross family income, for those enrollees below 200 percent of the federal poverty level; includes no dental care, nominal co-payments of \$10 per office visit, \$5 for medication, \$25 for inappropriate emergency room use, and a 25 percent discount from the traditional fee for service system. Limits plan enrollment to 30,000 individuals eligible for subsidies at sites in at least five congressional districts. Requires the administrator to seek multiple participation agreements to allow enrollees a choice of managed health care systems, which will provide care under the plan.

WEST VIRGINIA, 1985, Chap. 103. Creates an indigent care fund to be financed by legislative appropriation. Allows West Virginia Health Care Cost Review Authority to assess all hospitals not owned by the state an aggregate maximum amount of \$3 million in FY-86. Hospitals must be assessed on a *pro rata* basis, based on a 3-year average of new revenues less expenditures and taxes, weighted by the hospital's ratio of West Virginia's gross Medicaid revenues to gross patient revenues. The fund supplements the state's Medicaid program, so the state may receive matching funds from the federal government. A legislative task force on uncompensated health care and Medicaid expenditures is commissioned to make recommendations by June 30, 1988, concerning health care for those who cannot afford it.

WEST VIRGINIA, 1986, Chap. 85. Continues the indigent care fund until June 30, 1987, and allows the state to assess hospitals an aggregate amount of \$3 million for the fund.

Laws Passed in 1985-87

Medicaid Changes

(Affects Numbers of Persons Without Medical Benefits
and Hospital Cost-Containment)

ALABAMA, 1987, Act 707 (S 587). Creates the Alabama Mothers and Babies Indigent Care Trust Fund; creates a board to administer and manage the funds. Provides for expansion of medical services available to needy pregnant women and to children under the Medicaid program of the Omnibus Budget Reconciliation Act of 1986, and for other expansions of the Medicaid program that are or become feasible.

ARIZONA, 1986, Chap. 380 (HB 2086). Extends coverage to "notch group" children, those under age six whose household incomes are above current eligibility levels in the Arizona Health Care Cost Containment System (AHCCCS, the state's alternative to Medicaid), but below federal poverty income guidelines. Requires counties to process the eligibility applications of pregnant women on a priority basis, and provides for continuous enrollment of a pregnant woman and her newborn child through the end of the month following the month of delivery. Requires that an applicant for AHCCCS intends to reside in Arizona indefinitely, and that the residency status of an applicant who has moved to Arizona within the past 6 months for the purpose of receiving state-assisted medical care be determined by a special eligibility officer. Adds to the category of persons who are eligible for federal matching dollars children under age 18 who meet AFDC income and resource criteria but not deprivation criteria. Increases from \$30,000 to \$50,000 the allowable net worth of resources and assets for medically needy/medically indigent eligibility. Clarifies that use of incurred medical expenses to "spendown" against resource and asset levels in determining eligibility is not allowed.

ARIZONA, 1987, Chap. 332 (SB 1418). Makes the following major changes in the current AHCCCS program; makes the AHCCCS program permanent in statute, adds coverage for children up to 2 years old and pregnant women with family incomes below the federal poverty level beginning January 1, 1988. Expands coverage of "notch group" children to include children who are 6-13 years of age. Eliminates the hospital rate freeze on October 1, 1988, providing a 3-year phase-in for rate increases.

CALIFORNIA, 1987, Chap. 1470 (AB 2594). Requires the California Medical Assistance Commission to give special consideration to the reimbursement

issues faced by hospitals caring for Medi-Cal beneficiaries who are receiving treatment for AIDS and to develop an expedited review process to examine the effectiveness of investigational drugs and investigational services, and their eligibility for Medi-Cal reimbursement.

COLORADO, 1986, Chap. 201 (SB 139). Defines as "categorically needy" those individuals who accepted jobs but would have been eligible for federally aided state assistance under the Social Security Act, and makes them eligible for medical assistance for a period not to exceed 9 months. The state Department of Social Services must apply to the federal Department of Health and Human Services for a waiver in order to qualify for federal funds under the Social Security Act, upon which eligibility under the program is contingent.

CONNECTICUT, 1987, P.A. 390 (HB 7149). Raises the Medicaid eligibility income limit from 120 percent of the standard of need to 133 percent of the standard of need.

FLORIDA, 1987, Chap. 92 (HB 1384). Extends Medicaid eligibility of pregnant women and children up to 100 percent of the federal poverty line and to elderly and disabled persons up to 90 percent of the federal poverty line, increases Medicaid provider fees, provides funding for annual adult health screening for Medicaid eligible adults, and implements the "presumptive eligibility" option.

ILLINOIS, 1987, P.A. 453, (HB 295). Extends Medicaid eligibility to children and to pregnant women up to 1 year of age with income limits for eligibility to be determined by the Department of Public Aid but no higher than 100 percent of the poverty level.

ILLINOIS, 1987, P.A. 85-929 (HB736). States explicitly that persons with AIDS are eligible for services provided under the existing home and community-based services waiver.

IOWA, 1985, Chap. 239. Appropriates general funds to extend operation of the medically needy program for supplemental security income related groups.

LOUISIANA, 1987, P.A. 760 (HB 1569). Raises from 80 percent to 100 percent the cost standard that must be exceeded for Medicaid recipients to receive home health care in place of institutional care.

MARYLAND, 1987, Chap. 286 (HB 1099). Extends Medicaid eligibility to pregnant women, infants, and children (below the age of one), who fall below the federal poverty level, as permitted by the Omnibus Budget Reconciliation

Act of 1986. Increases the age limit for children's eligibility by one year each succeeding calendar year, up to a maximum age of three.

MINNESOTA, 1987, Chap. 403 (HF 243). Extends Medicaid eligibility to pregnant women with incomes up to 133 1/3 percent of the AFDC income eligibility standard.

MISSISSIPPI, 1987, Chap. 513 (SB 2641). Expands Medicaid services to all pregnant women with incomes below the poverty level. Increases the number of Medicaid reimbursable hospital days for children from 15 to 30 per year, and increases physician fees for delivering babies. Allows hospitals with a disproportionate share of charity work an additional 5-percent increase in payments.

MISSOURI, 1987, p. 625 (HB 518). Makes Medicaid benefits available to pregnant women who would be eligible for AFDC, even without a dependent child in the home or where such a child would not be deprived of parental support, and pregnant women, infants, and children who would be eligible for assistance under SOBRA. Sets income eligibility standards equal to 100 percent of the federal poverty level. Expands third-party liability recovery powers and programs.

NEW JERSEY, 1987, Chap. 115 (AB 2733). Extends Medicaid eligibility to pregnant women and to infants in families with incomes below the federal poverty level, and to children below the age of one beginning April 1, 1987. Increases the age limit for children by one year each succeeding October 1, up to age five in 1990.

NORTH CAROLINA, 1987, Chap. 738 (H 1514). Extends Medicaid coverage to pregnant women and to children up to age five, whose family income is equal to or less than 100 percent of the federal poverty guidelines. Continues services to pregnant women eligible under the new provision throughout pregnancy, but includes only services that are related to pregnancy and other conditions determined to be conditions that may complicate pregnancy.

NORTH CAROLINA, 1987, Chap. 861 (S 1018). Requires the Division of Medical Assistance to develop, as part of the Medicaid Hospital Reimbursement Plan, a new method for increasing per diem rates to hospitals that serve a disproportionate share of indigent patients. Requires the plan to take into account charity care provided in inpatient, outpatient, pharmaceutical, and pregnancy-related services to patients with incomes less than 200 percent of the poverty level.

OKLAHOMA, 1987, Chap. 179 (HB 1307). Provides for inclusion of pregnant and postpartum women and infants under one year of age with incomes up to 100 percent of the poverty level into the Medicaid program. Provides for future extension of program eligibility to include children up to four years of age.

OREGON, 1987, Chap. 872 (SB 543). Expands Medicaid eligibility to pregnant women and children for whom federal financial participation is available.

SOUTH CAROLINA, 1985, Act 201. Directs the Health and Human Services Finance Commission to implement cost containment measures to include, but not be limited to, utilization reviews, preadmission certification, mandatory outpatient surgery, a second surgical opinion pilot study, and procedures to encourage the use of outpatient services.

RHODE ISLAND, 1987, Chap. 463 (S 10). Adopts expanded eligibility standards for medical assistance to pregnant women and children up to five years of age, and permits pregnant women to receive medical assistance on a presumptive eligibility basis while their eligibility is being determined.

TENNESSEE, 1987, Chap. 332 (SB 867). Extends optional Medicaid coverage to pregnant women, infants, and children, in accordance with the provisions to the Omnibus Budget Reconciliation Act of 1986 and subject to funding availability in the annual appropriations act.

WASHINGTON, 1985, Chap. 335. Makes corresponding changes in state law to comply with federal law, including use of Internal Revenue Services data to verify recipient eligibility, guidelines for use of general assistance and emergency assistance funds, and guidelines for maximizing federal participation. The family income eligibility standard is raised from 150 to 180 percent of the state standard of need. Conditions are set forth whereby a person would be ineligible for assistance because of excess real property.

WEST VIRGINIA, 1987, Chap. 65 (HB 2216). Requires the Department of Human Services to participate in the Medicaid program for indigent children and pregnant women established by Congress. Increases Medicaid reimbursement rates for prenatal care, delivery, and postpartum care to \$600.

WISCONSIN, 1987, Chap. 27 (SB 100). Increases Medicaid recipient copayments and requires a study of the impact of the increase on use of services. Allows incentive payments to counties that identify payment sources other than Medicaid. Enacts presumptive eligibility criteria for pregnant women.

WISCONSIN, 1987, Chap. 27 (SB 100). Provides for Medicaid eligibility for up to 12 months following ineligibility for AFDC due to failure to satisfy income criteria only for persons participating in a pilot demonstration project.

Medically Uninsurable (Risk Pools)

FLORIDA, 1987, Chap. 345 (SB 504). Extends sections of the State Comprehensive Health Association Act, the state Insurance pool for uninsurables, beyond October 1, 1987; offsets assessments paid by insurers to the association against the insurers' state corporate income tax or premium tax; sets the initial rate at 150 percent of the standard risk rate; requires that any change in the rate reflects reasonably anticipated losses and expenses; and caps the rate for plans issued through the association at 200 percent of the standard risk rate.

ILLINOIS, 1986, P.A. 84-1478 (SB 1699). Establishes the Comprehensive Health Insurance Plan Act for persons who have been rejected by one insurer, or if an insurer refuses to issue insurance except at a rate exceeding the plan rate. Rates will be 135 percent of rates established as applicable for individual risks. Deficits will be recouped by a legislative appropriation. Establishes other administrative policies.

ILLINOIS, 1987, P.A. 85-702 (SB 630). Allows the Illinois Comprehensive Health Insurance Plan to employ cost containment measures such as preadmission review, second surgical opinions, HMO coverage, and adjustment of premiums based on individual risk factors; makes Medicaid recipients ineligible for coverage, caps total payments to a single policyholder at \$500,000.

IOWA, 1986, Chap. 1156 (HF 2181). Creates an Iowa Comprehensive Health Association as a nonprofit association of persons offering health insurance in the state to provide medical coverage for persons unable to obtain health insurance, or at a prohibitive cost. Premium costs are to be not more than 150 percent of the average premium charged for comparable coverage by the five insurers with the largest health insurance premium or payment volume in the state. Annual out-of-pocket expenses are limited.

KANSAS, 1986, Chap. 178 (SB 121). Creates a joint underwriting plan to make insurance available to persons unable to secure it in the market. Legislative approval is required for implementation.

MAINE, 1987, Chap. 347 (LD 1770). Establishes the Maine High-Risk Insurance Organization to make health insurance available for individuals unable to obtain adequate health insurance because of existing health conditions. Funds

losses from the plan by an annually-adjusted assessment on hospital revenues not to exceed .0015 percent of hospital revenues, limits enrollment to 300 persons and sets administrative policies.

MONTANA, 1985, Chap. 595. Establishes a program for health insurance coverage to those who are considered medically uninsurable.

NEBRASKA, 1985, L.B. 391. Establishes the Nebraska Comprehensive Health Insurance Pool for persons who are uninsured or underinsured due to a pre-existing medical condition. Initial premium rate is set at 135 percent of the standard risk and subsequent rates no more than 165 percent. The lifetime benefit is \$500,000 for any one person. Deficits in the pool are made up by reduction in tax credits of insurers.

NEW MEXICO, 1987, Chap. 154 (SB 294). Establishes the New Mexico Comprehensive Health Insurance Pool to provide health insurance to persons considered uninsurable; assesses insurers to cover any losses from pool operations; sets administrative policies.

NORTH DAKOTA, 1985, Chap. 322. Reduces from two to one the number of rejection certifications from health insurers for eligibility in the Comprehensive Health Association plan. It requires prior residency in the state of six months for eligibility; provides for coverage of a pre-existing condition during the first six months of coverage if the insured pays an additional premium.

OREGON, 1987, Chap. 838 (SB 583). Creates the Oregon Medical Insurance Pool to insure high-risk uninsurables; limits premiums to 150 percent of the standard risk; sets administrative policies.

TENNESSEE, 1986, Chap. 870 (HB 1778). Creates the Tennessee Comprehensive Health Insurance Pool to provide health insurance coverage to persons denied adequate health insurance for any reason from any insurer. Premiums are to be up to 150 percent of the standard risk rates, specified deductibles and coinsurance up to a maximum. Cost containment measures are to be employed. Losses are to be funded through assessments on insurers, but the total not to exceed the state's contribution to the pool (limited to \$2 million per year).

WASHINGTON, 1987, Chap. 431 (HB 99). Creates a non-profit comprehensive health insurance pool; defines eligibility as persons who have been rejected for coverage within a six-month period prior to application. Deficits are

financed by assessments of all health insurers, health care service contractors, and HMOs.

WISCONSIN, 1986, Acts 29 and 120 (AB 85 and Jan. Spec. Sess. SB 1). Provides premium subsidies to low income policyholders under the health insurance risk-sharing plan and expands eligibility for the plan. Act 120 also reduces the funding provided in Act 29 for the premium subsidies.

Patient Transfers (Dumping)

CALIFORNIA, 1987, Chap. 1240 (SB 12). Regulates the treatment of patients brought to hospital emergency departments and the transfer of those patients to other medical facilities. Prohibits basing emergency patients' treatment on patients' race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical conditions, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, unless the circumstances are medically significant to the provision of appropriate medical care. Specifies conditions under which emergency medical patients may be transferred and procedures that may be followed. Requires hospitals to adopt policies and transfer protocols consistent with the bill, and makes hospitals' compliance with specified procedures a condition of licensure.

FLORIDA, 1986, Chap. 125 (SB 1036). Expands the duties of hospitals with full-time emergency rooms for treating persons seeking emergency medical care. Upon the determination of a hospital physician to admit a patient for emergency care, a hospital may not refuse to admit a patient on the basis of economic criteria or indigency. If the hospital is unable to render appropriate treatment, it may transfer the patient, meeting specified guidelines, and only when the physician considers the patient stable enough for transfer.

LOUISIANA, 1986, P.A. 998 (HB 1058). Prohibits hospitals from denying emergency services to a person diagnosed by a licensed practitioner as requiring emergency services due to inability to pay or due to race, religion, or national ancestry. The act also makes the same prohibitions related to access to diagnosis by a licensed physician. A hospital that recklessly or intentionally violates the act may be subject to a fine of not more than \$5,000, and may be suspended from the medical assistance program.

MARYLAND, 1986, Chap. 849 (SB 711). Requires the Department of Health and Mental Hygiene to adopt regulations governing the transfer of patients between hospitals and specifies minimum requirements to be included in those regulations. Hospitals must adopt binding policies relating to patient transfers.

MASSACHUSETTS, 1986, Chap. 107 (S 465). Provides that if a health care facility refuses to treat a patient due to that patient's economic status or lack of a source of payment, the facility becomes responsible for finding a facility to treat the patient, ascertaining that the patient may be safely transferred, securing the patient's safe and comfortable transportation to that

facility, assuring that the patient will promptly receive necessary care, providing pertinent medical information about the patient's condition, and maintaining records of the foregoing.

NEVADA, 1987, Chap. 377 (AB 289). Requires hospitals to provide emergency medical care to all patients, regardless of financial status, and allows hospitals receiving "dumped" patients to recover treble costs.

NEW YORK, 1987, Chap. 121 (A3183). States that no general hospital shall transfer patients to another hospital or health care facility on the grounds that the patient is unable to pay or guarantee payment for services rendered.

OREGON, 1987, Chap. 386 (HB 2354). Prohibits hospitals from denying services to persons diagnosed by a physician as needing emergency medical services because of the person's inability to pay.

PENNSYLVANIA, 1986, Act 89 (SB 293). Requires health care providers (hospitals, ambulatory service facilities, and physicians) as a condition of licensure, to provide medically necessary lifesaving and emergency health care services to people regardless of their financial status or ability to pay, and also stipulates that health care facilities may transfer patients only when they lack the staff or facilities to "properly render definitive treatment."

TENNESSEE, 1986, Chap. 711 (SB 1410). Requires the Department of Health and Environment to promulgate rules to regulate the transfer of inpatients between hospitals to prevent involuntary transfer for purely economic reasons. The department is to provide standards governing inpatient transfers, in accordance with specified guidelines. Hospitals are required to adopt policies consistent with the rules and standards.

Laws Passed 1985-87

Medical Insurance (Special Considerations)

CONNECTICUT, 1987, P.A. 274 (HB 5047). Increases the extension period under group health insurance policies from 39 to 78 weeks for group members and their families when members lose their jobs, and from 39 to 156 weeks for surviving or former spouses and children when group members die or are divorced from their spouses. Members or families pay from 100 percent to a maximum of 102 percent of premium.

COLORADO, 1986, Chap. 84 (SB 51). Requires group sickness and accident insurance policies and group contracts issued by non-profit hospital, medical-surgical, and health service corporations and by health maintenance organizations to contain a provision which permits an eligible employee, upon termination of his employment, to elect to continue the coverage for himself and his dependents for up to 90 days or until the employee becomes reemployed, whichever occurs first. There must also be a provision that the employee, spouse, or dependent, at his expense, may elect individual coverage upon expiration of the continued group coverage.

DELAWARE, 1986, Chap. 461 (SB 578). Permits self-employed people to deduct from their state income taxes one half the amount of health insurance costs they pay for themselves, spouses, and dependents to the extent that these costs exceed the federal government's deductible for medical expenses.

GEORGIA, 1986, P. 688 (HB 212). Provides that group health insurance plans, and other group medical benefit plans must contain provisions for continuation and conversion of coverage for group members whose coverage is terminated. The group member who has not been terminated for cause or discontinued payment of the premium may elect to purchase an additional three months of coverage.

ILLINOIS, 1985, P.A. 84-556. Requires all group health and accident insurance policies contain a provision for continuation for an employee's spouse or dependent children in case of the employee's death or divorce from spouse. Termination of benefits may occur due to remarriage, eligibility under another employer's group plan, failure to pay premiums, or two years from the date of continuation- at which time the person may convert to individual coverage.

INDIANA, 1986, P.L. 165 (HEA 1432). Provides that hospital or medical expense coverage for the dependent child of a group accident and sickness policy does not terminate upon the child's attainment of the policy's limiting age if the child is not capable of self-sustaining employment due to mental retardation or a physical handicap and is chiefly dependent on the group member for support.

IOWA, 1986, Chap. 1124 (HF 2465). Requires that group members whose insurance is discontinued due to employment termination receive extended coverage for nine months. Excludes members who are eligible for Medicare or other insurance or health plans or those who were not continuously insured by the group for the preceding three months; requires employees to pay the entire premium; makes conversion policies available to surviving spouses and children upon the death of the group member.

KENTUCKY, 1986, Chap. 163 (SB 274). Allows continuation of group policies upon termination of group membership under certain circumstances; extends continuation and conversion privileges to the surviving spouses, children, and former spouses under certain conditions.

MAINE, 1986, Chap. 684 (LD 2273). Requires insurers to allow continuation of group insurance coverage or conversion to individual coverage for employees laid off or terminated due to work-related injury or occupational disease. If the employee purchases continued group coverage, the insurer may not charge more than the group rate in effect and must continue coverage for six months to one year, depending on the employee's physical condition.

MARYLAND, 1986, Chap. 681 (SB 632/HB 922). Provides a continuation for up to 18 months of group health coverage for the surviving spouses and dependents of an insured covered under a group health insurance contract. The surviving spouse pays premiums at the group rate, and pays the amount of the employer's contribution.

MARYLAND, 1986, Chap. 747 (HB 840). Creates the Maryland Group Health Insurance Plan, which provides for group health insurance for unemployed individuals, and for divorced or widowed spouses who are not eligible for group health insurance. The group plan requires the insurance commissioner to determine the specifications of the plan, including benefits, premium rates, and deductible and copayment provisions. The commissioner is to select an authorized insurer to underwrite the plan.

MASSACHUSETTS, 1986, Chap. 579 (SB 1978). Requires insurers to provide continuation coverage to employees whose coverage is terminated due to a

plant closing or partial closing for a period of 90 days, or until they become eligible for other insurance.

MICHIGAN, 1986, Act 121 (HB 5018). Authorizes the establishment of multiple employer welfare arrangements (MEWA) to provide medical, surgical, hospital, and other benefits to employees. To qualify for a certificate of authority, employers in the MEWA must be members of an association or group of five or more businesses that are in the same trade or industry, and must meet other specified criteria. A MEWA security fund is created to be used to pay covered claims against insolvent MEWAs. Each MEWA will be assessed an amount determined by a formula to finance the security fund.

MINNESOTA, 1987, Chap. 337 (SF 478). Provides for continuation of insurance for spouses, dependents, and former spouses; requires group insurance policies renewed after August 1, 1987 to allow terminated or laid-off employees to elect to continue coverage for up to 18 months; provides for conversion to individual policies.

MISSOURI, 1985, Revised Statutes Sect. 376.421 to 376.442. Allows continuation of coverage for members, dependents and divorced spouses for up to nine months following the termination of employment. Requires group plans to extend major medical coverage to the totally disabled for at least 12 months after date of disablement.

NEVADA, 1987, Chap. 805 (SB 155). Requires employers with fewer than 20 employees to offer terminated employees the option of continuing their health insurance coverage with the former employees paying the entire premium; requires the option also be available to spouses and families of employees who die.

NEW HAMPSHIRE, 1986, Chap. 163 (H 155). Continues health and accident insurance for divorced and separated spouses until remarriage and provides conditions for conversion of benefits after remarriage.

NEW YORK, 1987, Chap. 210 (S 7). Ends the state-mandated, six-month insurance continuation coverage of group health or hospital insurance offered to employees or members and their covered dependents under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

NEW YORK, 1987, Chap. 539 (A 6880). Established a five-month health insurance benefit program for dislocated (laid off) workers; sets eligibility criteria; requires the governor to submit a plan to assist dislocated workers with premium payment.

NORTH CAROLINA, 1987, Chap. 765 (S 759). Establishes the North Carolina Health Insurance Trust Commission to organize a health insurance program for businesses with 25 or fewer employees by developing benefit plans, provider participation criteria, employer and employee eligibility criteria, and administrative contracts.

OKLAHOMA, 1985, Title 36. Includes maternity coverage as a "continuous loss" for which insurance coverage may be continued after termination of employment.

OKLAHOMA, 1986, Chap. 150 (SB 545). Allows disabled employees or their survivors to continue health and dental insurance if they are in the State Employees Disability Program and they pay full premiums.

OREGON, 1987, Chap. 591 (HB 2594). Establishes the Insurance Pool Governing Board to offer health insurance to employers with less than 25 employees who have not contributed to employee health insurance premiums within the preceding two years and who agree to make a minimum contribution toward employee premium costs; defines "Part I " coverage to cover episodic acute care and recovery care for employees only and requires a minimum employer contribution toward premium costs; defines "Part II" coverage as optional enhancements and coverage for employees' families; gives participating employers decreasing annual tax credits for amounts paid into the pool.

TENNESSEE, 1986, Chap. 716 (SB 1507). Entitles divorced or surviving spouses of the insured person up to 15 months of insurance continuation at the group rate if they pay the full premium to the employer and meet other conditions. Persons whose group coverage is terminated during pregnancy are entitled to have their coverage continued under the group policy until at least six months after the pregnancy ends.

WASHINGTON, 1986, Chap. 223 (HB 1630). Requires every health care service agreement to assure a covered spouse and/or dependents the right to continue the agreement without a physical examination, statement of health, or proof of insurability if they cease to be qualified family members. It also prohibits termination due to a change in the physical or mental condition or health of a person unless certain conditions are met.

WISCONSIN, 1986, Act 311 (AV 12). Specifies that parents' liability for the health care expenses of their minor's child extends to all expenses of the child's medical care and treatment, including childbirth, regardless if the

expenses were incurred prior to a paternity determination, unless they exceed five percent of the parents' federal adjusted gross income from the previous taxable year. The act also requires health insurance policies that provide coverage for an insured's child to also provide coverage for children of that child until the child is 18 years of age.